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IN THE

Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Fifth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

JOHN B. SHELY
KENDALL M. GRAY
ANDREWS & KURTH LLP
600 Travis, Suite 4200
Houston, Texas 77002
(713) 220-4200

MIGUEL A. ESTRADA
Counsel of Record
RACHEL A. CLARK
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Respondents

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, preempts the independent review requirements established by Texas Senate Bill 386.

2. Whether the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 *et seq.*, preempts the independent review requirements established by Texas Senate Bill 386.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. All respondents are indirect subsidiaries or affiliates of Aetna, Inc., a publicly traded company.

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JURISDICTION

The judgment of the court of appeals was entered on June 20, 2000. A petition for panel rehearing was denied on July 27, 2000. Pet. App. D1, D6. The petition for a writ of certiorari was filed on October 24, 2000. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Texas' Senate Bill 386, the Supremacy Clause of the United States Constitution and the pertinent provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* and the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 *et seq.* are reproduced in the appendix to this brief.

STATEMENT

1. In 1997, Texas enacted Senate Bill 386 ("SB 386"). The law purports to subject managed care organizations ("MCOs") to a set of independent review requirements through which members may appeal adverse determinations of medical necessity made by an MCO. Specifically, SB 386 applies to any "preferred provider organization" ("PPO"), "health maintenance organization" ("HMO"), or "any other person or entity which provides * * * or administers * * * health benefits * * * pursuant to a policy, plan, or contract." TEX. INS.

CODE ANN. art. 21.58A §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A (West 1999).[1] The Texas statute requires MCOs to fund an independent review by a state-approved organization ("independent review organization" or "IRO") whenever an MCO's utilization review agent denies a plan enrollee's appeal of an adverse coverage determination. TEX. INS. CODE ANN. arts. 20A.09, 20A.12A, & 21.58A (West 1999); Pet. App. E1-E2, E4, E6-E7. In addition, the state provisions mandate that MCOs must "comply" with the IRO's determination of the "medical necessity" or "appropriateness" of the particular health care coverage at issue. *Id.* at E5.[2]

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[1] SB 386 applies by its terms to insurers writing health insurance policies, to self-insured plans, employers with employees in Texas who are covered under a health benefit plan or health insurance policy, and administrators as defined by article 21.07-6 of Texas Insurance Code. TEX. INS. CODE ANN. art. 21.58A §§ 2(2), 2(17)(A) and (B), 2(21)(A), (B) and (C), 6, and 6A (West 1999). While Section 14(e) of Article 21.58A purports to exempt ERISA plans from the IRO provisions, Texas nevertheless sought to apply them both to ERISA plans and to entities that administer benefits on behalf of those plans. Appearing as amicus in support of Texas in the courts below, the Secretary of Labor called the meaning of Section 14(e) "uncertain" under state law, and therefore characterized federal review as "premature." *See* Brief of Secretary of Labor as *Amicus Curiae* 23-27 (5th Cir. Mar. 12, 1999).

[2] The validity of the law's other provisions—which purport to establish liability for MCOs that fail to meet an "ordinary care" standard ("the liability provisions") and to prohibit MCOs from including indemnification clauses in their contracts and from retaliating against doctors or health care providers for advocating health care coverage ("the anti-indemnification and anti-retaliation provisions")—is not at issue before this Court. Even so, the court of appeals did not hold, as Texas implies, that one might use SB 386 (or any

[Footnote continued on next page]

2. Respondents—several indirect wholly-owned subsidiaries of Aetna, Inc.—are MCOs that are subject to SB 386's independent review provisions. Respondent Aetna Life Insurance Company, for example, makes coverage determinations for employee benefit plans (both insured and self-funded) governed by ERISA. *See* Record at 20:72-75. The petitioners are Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas (collectively "Texas").

After SB 386 was enacted, respondents (hereinafter "Aetna") filed suit against Texas in federal district court, seeking declaratory and injunctive relief. With respect to the issues pertinent here, Aetna asserted that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and the Federal Employees Health Benefit Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, preempt the Texas statute's independent review provisions.

On cross-motions for summary judgment, the district court ruled, in pertinent part, that ERISA preempts the IRO provisions of SB 386. First, the court held that ERISA's express preemption provision, ERISA § 514(a), 29 U.S.C. § 1144(a), preempts the independent review provisions because they would "improperly mandate the administration of employee benefits" and would interfere with "the goal of uniformity [in ERISA

[Footnote continued from previous page]
other state law theory) to sue an MCO for improper benefits determinations, based on medical necessity or otherwise. In order to conclude that the liability provisions are not necessarily preempted in all of their applications, the court of appeals construed those provisions as applying only to a "limited universe of events," namely vicarious liability claims arising from the professional malpractice of a treating physician. *See, e.g.*, Pet. A8-A9.

plan regulation] that Congress sought to implement" through Section 514(a). Pet. App. B66-B67 (citation omitted). The court next concluded that SB 386 is not a state law regulating insurance under ERISA's saving clause, ERISA § 514(b)(2)(a); 29 U.S.C. § 1144(b)(2)(A). The court reasoned that, "on its face, the Act is obviously not 'limited to entities within the insurance industry.' Even though the Act lists health insurance carriers as one group covered by its terms, it also specifies that it applies to health maintenance organizations and other managed care entities for a health care plan." Pet. App. B15 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985)).[3]

With respect to Aetna's claim that SB 386 also creates an impermissible alternate enforcement mechanisms, the court concluded that courts should determine on a case-by-case basis "[w]hether a claim seeks review of an adverse benefit determination [which would require preemption] or to secure quality coverage [which would not]." *Id.* at B76-B77. The court reached a similar conclusion on Aetna's claim that FEHBA preempts SB 386. *Id.* at B80. Having determined, however, that SB 386's independent review provisions are preempted by ERISA's express preemption provision and not saved under the saving clause, the court severed the IRO provisions from the remainder of the bill. *Id.* at B67-B68.

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[3] Because the district court ruled on the preemption question before this Court decided *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), the court relied on Fifth Circuit precedent that required that a state regulation must satisfy all three McCarran-Ferguson factors in order to be viewed as a regulation of insurance under ERISA's saving clause. After determining that SB 386 failed the third factor because it is not limited to entities within the insurance industry, the district court thus had no occasion to analyze the other factors.

3. The court of appeals affirmed in part and reversed in part, concluding in pertinent part that ERISA and FEHBA preempt the independent review provisions of SB 386. Pet. App. A1-A26.

The court first held that Texas' IRO provisions fall squarely within the scope of ERISA's express preemption provision: "The [independent review] provisions allow a patient who has been denied coverage to appeal to an outside organization. Such an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." Pet. App. A13. The court then held that ERISA's saving clause does not save the IRO provisions from preemption. Pet. App. A13-A16. The court first noted that the independent review provisions meet two of three factors for identifying the business of insurance under the McCarran Ferguson Act, 15 U.S.C. § 1012: although those provisions "probably do not * * * reallocat[e] * * * risk," they are aimed at insurers and regulate the insured-insurer relationship. *Id.* at A13-A14. The court noted, however, that the McCarran-Ferguson factors are not the end of the analysis under ERISA's saving clause, because *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), held that the clause does not save state laws that conflict with Section 502(a) of ERISA, 29 U.S.C. § 1132(a). Pet. App. A15.

The court explained that the independent review procedures conflict with Section 502(a) because they bind ERISA plans to the decisions of IROs regarding whether benefits must be paid, and "create[] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under § 1132(a)(1)(B) of ERISA." Pet. App. at A15-A16. The court therefore held that Texas' independent review provisions "conflict with ERISA's exclusive remedy and cannot be saved by the savings clause." *Id.* at A16.

Finally, the court of appeals determined that FEHBA preempts the independent review provisions under general conflict principles because those provisions conflict with the administrative remedy concerning benefits disputes provided by the Office of Personnel Management under FEHBA. Pet. App. A17 (citing 5 U.S.C. § 8902(j); 5 C.F.R. § 890.105-890.107). Having found the independent review provisions preempted, the court then severed them from the remainder of the statute.

4. Texas sought rehearing of the panel's ruling that ERISA and FEHBA preempt SB 386's IRO provisions, contending that that ruling was contrary to *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). The court denied rehearing, but it issued a supplemental opinion rejecting Texas' reliance on *Pegram*. The court explained that *Pegram* held that mixed eligibility and treatment decisions made by an HMO through its physicians are not fiduciary acts under ERISA, but that *Pegram* did not "entail that every conceivable state law survives preemption so long as it is based on a mixed question of eligibility and treatment." Pet. App. D2-D3.

The court also rejected Texas' characterization of its IRO program as a law that merely implements a minimal level of care, like the state law at issue in *Metropolitan Life Ins. Co.*, 471 U.S. at 731, 758, by imposing a mandatory insurance contract term. The court concluded instead that "the IRO provisions here are plainly a state regime for reviewing benefit decisions." Pet. App. D6.

ARGUMENT

Texas contends that certiorari is warranted to resolve two distinct questions. First, Texas contends that this Court should decide whether a state law that conflicts with the exclusive remedies set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), can nonetheless avoid federal preemption if that law regulates "insurance"

within the meaning of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A). Second, Texas argues that this Court should consider whether state laws that provide for external review of an MCO's determination that a particular treatment is not "medically necessary" are preempted by ERISA or FEHBA. There is no conflict among the lower courts with respect to Texas' proposed first question, which in any event is not properly presented in this case. With respect to the second question framed by Texas, the Fifth Circuit's ERISA preemption analysis could be viewed as inconsistent with the approach employed by the Seventh Circuit in a recent case, but any conflict between those two decisions is not yet ripe for this Court's review. Accordingly, plenary review is not warranted.

I. THIS CASE DOES NOT PROPERLY PRESENT THE ISSUE WHETHER STATE STATUTES THAT CONFLICT WITH THE EXCLUSIVE REMEDIES SET FORTH IN SECTION 502 ARE SAVED FROM PREEMPTION BY ERISA'S "SAVING CLAUSE."

1. Texas first presents the question whether Section 502(a) of ERISA, 29 U.S.C. § 1132(a), is "an exclusive remedy provision that preempts state insurance law remedies" that purportedly fall within the insurance "saving clause" of Section 514 of the statute, 29 U.S.C. § 1144. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), however, this Court unanimously concluded that the remedies set forth in Section 502(a) are indeed exclusive. As the Court explained:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of [policy choices.] The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free

> to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54. This Court found additional support for the exclusivity of Section 502(a)'s remedies in the legislative history of ERISA, which demonstrated that Congress modeled the preemptive force of Section 502(a) on Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"). *See Pilot Life*, 481 U.S. at 55. As this Court noted, Congress well understood that Section 301 of the LMRA preempts state statutes "even when [they] purport[] to authorize a remedy unavailable under the federal provision." *Pilot Life*, 481 U.S. at 55. Indeed, "the entire comparison of ERISA's § 502(a) to § 301 of the LMRA[] would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws." *Pilot Life*, 481 U.S. at 56.

In light of this Court's analysis in *Pilot Life*, any state law that purports to "supplement[] or supplant[]" the exclusive remedies that Congress made available in Section 502(a) is invalid under conventional conflict preemption principles. *See, e.g.*, *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) ("In the face of [a] direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand"). Texas submits, however, that the Court's analysis in *Pilot Life* does not control when, as Texas contends is the case here, the state law falls within the scope of ERISA's saving clause, 29 U.S.C.§ 1144(b)(2)(A). *See* Pet. 12-17. That argument is at odds with the specific reasoning of *Pilot Life*, which examined the effect of Section 502(a) in order to inform the Court's "understanding of the saving clause," *Pilot Life*, 481 U.S. at 52, and found Section 502(a)'s exclusive remedy to be an important factor in

determining that the state law was *not* saved under ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *See Pilot Life*, 481 U.S. at 57.[4] As the Eighth Circuit has observed, "*Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape * * * preempti[on] * * * as laws 'which regulate insurance' under § 1144(b)(2)(A)." *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988).

2. Texas correctly notes that the Solicitor General, whose reasoning was adopted by this Court in *Pilot Life*, *see Pilot Life*, 481 U.S. at 52, retreated from his position in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), and now apparently believes that ERISA's saving clause may save from preemption even statutes that conflict with the exclusive remedies provided by Section 502 of ERISA. *See UNUM*, 526 U.S. at 376-77 n.7. At the outset, that contention overlooks key aspects of this Court's analysis in *Pilot Life*. *Pilot Life* did not merely hold that Section 502 remedies are exclusive, and thus preemptive of conflicting state laws under conventional conflict preemption principles. *Pilot Life* also held that the exclusivity of Section 502 remedies is so important to ERISA's design that it must inform judicial interpretation of the scope of the business of "insurance" that Congress intended to reserve for the States. That statutory term, the Court held, must be defined not only

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[4] Indeed, in *Pilot Life* this Court noted that its "understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a)," and it found that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not saved. *See Pilot Life*, 481 U.S. at 52, 57. Texas' arguments here would turn that analysis on its head.

on the basis of the McCarran-Ferguson guideposts, but also with reference to "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 52. Thus, Texas errs at the outset in presuming that Congress intended to save for the States the authority to regulate anything that might be viewed as "insurance" under a common sense application of two out of the three McCarran-Ferguson guideposts.

In any event, by accepting the Solicitor General's arguments, *Pilot Life* did not purport to give the Solicitor General a continuing proxy to change the rule of law that this Court unanimously adopted in that case—a rule that for nearly fifteen years has been part of the accepted understanding of ERISA shared by litigants and the lower courts. Indeed, far more than the Solicitor General's change of heart would be necessary to meet the high burden that must be "borne by the party advocating the abandonment of an established precedent," especially where, as here, "the Court is asked to overrule a point of statutory construction." *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989).

Moreover, contrary to Texas' assertions, there is no conflict among the courts of appeals on the question whether ERISA's saving clause preserves from preemption state statutes that conflict with ERISA's substantive provisions. Although Texas suggests that the Seventh Circuit's recent decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), adopted such a view, *see* Pet. 6-12, the Seventh Circuit did not remotely suggest that it was departing from *Pilot Life*'s unanimous teaching that Section 502 is an exclusive provision that preempts State laws that provide alternative or additional remedies to plan participants or beneficiaries. *Moran* concluded that an Illinois statute that provides for a form of external review could not properly be characterized as an alternative or supplemental enforcement mechanism precluded by Section 502(a), but rather was a permissible "mandated contract term" that became

part of ERISA plans—and thus is enforceable in an action under Section 502(a)—by operation of state law. Because the Seventh Circuit did not view the Illinois statute as an impermissible state mechanism for enforcing plan benefits, it found that the statute did not run afoul of Section 502's exclusive sweep. *Moran*, 230 F.3d at 970-72. That is far from holding that, were the statute properly characterized as an alternative or supplemental enforcement mechanism, it could nonetheless be saved from preemption by the saving clause.[5]

Texas is even wider of the mark in claiming that *Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995), and *PAS v. Travelers Ins. Co.*, 7 F.3d 349 (3d Cir. 1993), show that "[t]he Second and Third Circuits do not view *Pilot Life* as an obstacle to saving state insurance law remedies from preemption or to enforcement of those remedies in a state proceeding." Pet. 15. In both *Williams Trust* and *PAS* the sole, narrow issue properly before the court of appeals was whether the state statutes at issue were so completely preempted by ERISA that the defendants were entitled to *remove* actions filed under those statutes to federal court. *Williams Trust*, 50 F.3d at 146; *PAS*, 7 F.3d at 351. As Texas doubtless is aware, this Court unanimously ruled—on the same day it decided *Pilot Life*—that any state cause of action that falls within the scope of the civil enforcement provisions of Section 502(a) is so inherently and completely preempted that such a cause of

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[5] *Moran* might be read as creating a conflict with the decision below only with respect to one half of the *second* question that Texas has framed—*i.e.*, whether ERISA (but not FEHBA) preempts state laws that provide external review of a managed care organization's decision not to cover a particular treatment on the ground that such treatment is not "medically necessary." As discussed more fully below, any such conflict is not ripe for review.

action may be removed to federal court. *See Metropolitan Life Ins. v. Taylor*, 481 U.S. 58, 66 (1987). The Court was careful to point out, however, that not all preemption defenses support removal jurisdiction, and the fact that a particular preemption claim does not support "complete preemption" removal means only that the preemption defense must be adjudicated by the state courts—it does *not* mean that the statute is *not* preempted. *See id.* at 63-64; *see also Rivet v. Regions Bank of Louisiana*, 522 U.S. 470, 475-77 (1998); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 165 (3d Cir. 1999), *cert. denied*, 120 S. Ct. 2687 (2000). The limited removal rulings in *Williams Trust* and *PAS* could not properly establish otherwise.

In any event, it is difficult to see how either *Williams Ins. Trust* or *PAS* can be read to support Texas' claim that ERISA's saving clause trumps all preemption defenses under the statute. In *Williams Ins. Trust* the case had been removed on the basis of ERISA's general preemption provision, 29 U.S.C. § 1144(a)—the very provision where the saving clause appears—and thus conflict preemption was not even at issue in the case. *See Williams Trust*, 50 F.3d at 147. *PAS* concluded that ERISA did not completely preempt a state insurance law that prohibited discrimination in the provision of mental health benefits, reasoning that such a law did *not* conflict with the provisions of Section 502(a). *PAS*, 7 F.3d at 356. Neither case can plausibly be read for the proposition that state statutes that *do* conflict with Section 502(a) are immune from preemption if they satisfy Texas' proposed interpretation of the saving clause.

3. Even if this Court were otherwise inclined to entertain the argument that *Pilot Life* should be revisited as Texas desires, this case would not be the proper vehicle in which to do so for three reasons. First, as explained more fully below, while the court of appeals correctly concluded that the saving clause does not save Texas' external review requirements, that court was mistaken in

believing that a common sense assessment of the McCarran-Ferguson factors points to the conclusion that Texas' statute regulates insurance. For that reason, an essential predicate for the question posed by Texas is simply missing in this case.

Second, although Texas has always maintained that its external review statute is not preempted by ERISA, it did not argue below that a statute that conflicts with the exclusive remedies provided by Section 502(a) may be saved nonetheless if the statute meets Texas' interpretation of ERISA's saving clause. Texas' argument has been—and remains, *see* Pet. 11, 13—that there is no conflict *at all* between Texas' external review statute and Section 502(a). Indeed, Texas advanced its saving-clause argument below solely in an attempt to establish that the external review provisions are not independently preempted by ERISA § 514(a) as laws "relat[ing] to" employee benefit plans, 29 U.S.C. § 1144(a). Texas did not urge below the legal issue on which it now seeks review: that the saving clause—interpreted solely by reference to the McCarran-Ferguson factors—is the beginning and end of the analysis for all preemption defenses under ERISA.[6] Not surprisingly, the court of appeals did not consider any such claim. Thus, review of that question would not be appropriate in this case solely because the court of appeals did apply ordinary principles of conflict preemption. *See, e.g., United States v. Williams*, 504 U.S. 36, 41 (1992) ("Our traditional rule * * * precludes a grant of certiorari * * * when the question

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[6] Such an argument would have required Texas to request that the court of appeals revisit *en banc* its analysis in *Ramirez v. Intercontinental Hotels*, 890 F.2d 760, 763-64 (5th Cir. 1989). Neither Texas' briefs before the panel nor its subsequent petition for rehearing *en banc* contained any such entreaty.

presented was not pressed or passed upon below") (internal quotation marks omitted).

Finally, although SB 386 by its terms expressly links the external review and liability provisions—thus strongly suggesting the existence of a state-law cause of action for members dissatisfied with the external review process—the court of appeals construed the liability provisions as extending only to "a limited universe of events"—*i.e.*, events that constitute medical negligence by a treating physician, for which the MCO would be vicariously liable. Pet. App. A8. In light of that construction, Texas now asserts that its external review provisions should be viewed as "creat[ing] a procedural right that an ERISA beneficiary can assert in a § 502(a) enforcement action." Pet. 11; *see also id.* at 13 (external review provisions are "incorporated into ERISA plans and supply the relevant rule of decision in a § 502(a) suit"). Aetna disagrees that Texas' external review requirements are a mere procedural mechanism or that state law may require "incorporation" of that mechanism into the terms of ERISA plans. Nonetheless, as Texas characterizes its own statute, this case does not present the distinct legal question whether the saving clause should be read to save state laws that conflict with Section 502(a). *See UNUM*, 526 U.S. at 377 n.7 ("We need not address the Solicitor General's current argument, for Ward has sued under § 502(a)(1)(B) for benefits due, and seeks only application of saved state insurance law as a relevant rule of decision in his § 502(a) action").

II. TEXAS' STATUTE IS CLEARLY PREEMPTED BY ERISA BECAUSE IT CONFLICTS WITH SECTION 502 AND IS NOT SAVED FROM SECTION 514 PREEMPTION.

Texas' independent review requirements purport to establish a binding alternate enforcement mechanism for claimants to receive plan benefits. That not only is precisely the sort of state law remedy that Congress in-

tended to preempt with ERISA's comprehensive remedial scheme in Section 502(a), but also runs afoul of ERISA's express preemption provision, 29 U.S.C. § 1144.

1. ERISA's express preemption provision provides that ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). Thus, any state law that "relates to" an ERISA plan must give way to ERISA's preemptive reach. This Court has "long acknowledged that ERISA's pre-emption provision is 'clearly expansive.'" *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). As this Court reaffirmed in *Travelers*, "§ 514 indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (citation omitted); *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) ("[Section 514] demonstrates that Congress intended to * * * establish pension plan regulation as exclusively a federal concern."). To that end, Section 514(a) preempts any state law that has a "connection with" or "reference to" such a plan. *Dillingham*, 519 U.S. at 324 (citation omitted).

The court of appeals in this case and the Seventh Circuit in *Moran*—the only courts of appeals that have considered whether ERISA preempts the type of statute at issue here—both correctly concluded that external review statutes plainly "relate to" ERISA plans under Section 514(a). Pet. App. A12-A13; *Moran*, 230 F.3d at 968-69. After all, a determination that a particular treatment is not "medically necessary" does not prohibit a member from *receiving* such a treatment; it is simply a judgment that the plan under which the member is covered is not obligated to *pay* for it—it is, in other words, a

coverage determination. *See, e.g., Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). By forcing ERISA plans to pay for treatments that, in the plan's view, are not *covered*, Texas' external review provisions would have the clearly impermissible effect of "mandat[ing] employee benefit structures or their administration" and of "binding plan administrators to a[] particular choice." *Travelers*, 514 U.S. at 658, 659; *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Indeed, because external review laws fundamentally interfere with the allocation and payment of plan benefits to participants and beneficiaries in accordance with the terms of the applicable plan documents, those laws go to the very core of ERISA. *See* ERISA § 2(b), 29 U.S.C. § 1001(b) ("[It is] the policy of this Act to protect * * * the interests of * * * beneficiaries" in ERISA plans); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (explaining that ERISA plans are "obligat[ed] . . . [to] determin[e] the eligibility of claimants").

In addition, Texas' independent review law, if permitted to survive ERISA preemption, would frustrate Congress's aim of "'avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'" *Travelers*, 514 U.S. at 657. As this Court explained in *Fort Halifax*:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants * * * [and] making disbursements * * * The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be re-

> quired to * * *. process claims in a certain way in some States but not in others * * *.

Fort Halifax, 482 U.S. at 9. Here, as in *Shaw*, *Holliday*, and *Alessi*, validation of Texas' external review law would impose inconsistent state requirements on the administration of ERISA plans and thereby frustrate ERISA's clear purpose to "secur[e] national uniformity in the administration of employee benefit plans." *Boggs*, 520 U.S. at 842.

Petitioners nonetheless contend that *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), stands for the proposition that the independent review provisions at issue here do not "relate to" an ERISA plan, because Pegram noted that coverage or "'eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment.'" Pet. 24, quoting *Pegram*, 120 S. Ct. at 2157. *Pegram* held that ERISA does not impose a fiduciary duty on HMO physicians for their mixed eligibility and treatment decisions, *Pegram*, 120 S. Ct. at 2158. Because *Pegram* was not a preemption case, this Court "ha[d] no occasion to discuss" the standards governing a § 502(a) claim for benefits nor "the interaction of such a claim with state law causes of action," *Pegram*, 120 S. Ct. at 2154 n.9; *see also id.* at 2158. Indeed, to the extent that *Pegram* even so much as hinted at any principle of preemption law, it at most suggested that a *physician* who makes coverage decisions in the course of treating his patients is not thereby shielded from the state's malpractice laws. That principle is unexceptionable but, as the court of appeals correctly noted in denying Texas' petition for rehearing, it is not particularly helpful to Texas here. Pet. App. D2-D3, n.7 (noting that even assuming that malpractice causes of

action are not preempted, SB 386's external review procedures "would still be preempted.").[7]

2. The court of appeals correctly concluded that ERISA's saving clause does not save the external review provisions of SB 386 from preemption. Pet. App. A15. The conflict between the external review provisions and Section 502(a) alone establishes that those provisions are not part of the business of "insurance" that Congress intended to save from preemption. *Pilot Life*, 481 U.S. at 52. But even if the inquiry were restricted to the McCarran-Ferguson factors and "a common-sense view of the matter" (*UNUM*, 526 U.S. at 367), the external review provisions do not regulate insurance within the meaning of the saving clause.[8]

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[7] Moreover, *Pegram* addressed mixed eligibility and treatment decisions in the context of a "staff model" managed care plan, in which physicians are employees of the plan and make coverage decisions on behalf of the plan. Aetna does not operate any "staff model" plans in Texas; as the court of appeals noted, Aetna contracts with *independent* providers and hospitals. Pet. App. A3. Indeed, under Texas law "staff model" plans would likely run afoul of the State's prohibition on the corporate practice of medicine. *See Garcia v. Texas State Bd. of Med. Examiners*, 384 F. Supp. 434, 437 (W.D. Tex. 1974) (*per curiam*), *aff'd*, 421 U.S. 995 (1975). Thus, it is hard to see how *Pegram*'s discussion of physicians who make both medical and coverage judgments could have any application to Aetna, which deals solely with coverage issues.

[8] The McCarran-Ferguson factors are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *UNUM*, 526 U.S. at 367; *see also Metropolitan Life*, 471 U.S. at 743. Although a law

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Texas' external review provisions do not "regulate insurance" under a common sense understanding, because Texas' law is not directed specifically at the managed care industry *as insurers* or even at the insurance industry in general. *See UNUM*, 526 U.S. 375; *Pilot Life*, 481 U.S. at 50. Rather, the IRO procedures provide a dispute resolution mechanism of certain coverage determinations (those involving "medical necessity"), a matter not unique to the insurance industry. To cite only the most obvious example, Texas' law expressly targets not merely entities that assume risk for health care services, but also "*any* other person or entity which * * * *administers* * * * health benefits * * * pursuant to a policy, plan, or contract." TEX. INS. CODE ANN. art. 21.58A §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A.

Senate Bill 386 thus quite clearly reaches not only plans in which Aetna assumes some financial risks of coverage, but also plans—particularly self-funded employee benefit plans—that Aetna merely administers in exchange for a fee. Texas' law expressly reaches, in other words, the prime example of what Congress intended for States *not* to reach under the guise of "insurance." *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (discussing ERISA's "deemer clause," 29 U.S.C. § 1144(b)(2)(B), which precludes states from using the saving clause to "deem" employee benefit plans "insurers" or to "deem" such plans "to be engaged in the business of insurance"). For that same reason, SB 386's external review procedures do not satisfy the third McCarran-Ferguson factor. Indeed, while the court of appeals dismissed the third McCarran-Ferguson factor on the

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need not meet all of three McCarran-Ferguson factors to fall within the protection of the saving clause, *see UNUM*, 526 U.S. at 373, the Court has continued to scrutinize all three factors.

theory that Texas may permissibly reach any "entities *acting* as insurers," Pet. App. A14 (emphasis in original), that is simply another way of saying that Texas could permissibly "deem" self-funded plans to be "insurers" for regulatory purposes, a boundless theory that would essentially nullify ERISA's "deemer clause." *See FMC Corp.*, 498 U.S. at 63-64.

Moreover, as the court of appeals essentially conceded, Texas' external review requirements do not meet the first McCarran-Ferguson factor because they do not operate to transfer or spread a policyholder's risk. *See* Pet. App. A15 ("the provisions probably do not meet the first factor"). Regardless of the particular remedy available to obtain benefits under the terms of a plan—whether under Section 502(a) or through a state mandated appeals process of independent review—the basic contract terms providing benefits to a policyholder for "medically necessary" health care remain controlling. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130-31 (1982). The relevant risk is fixed when the contract is completed (*id.* at 131), and—notwithstanding Texas' law—a member's health plan continues to bear the risk of covering only "medically necessary" health care, while members continue to bear the financial risk of covering any desired health care that is not medically necessary.

Finally, given Texas' current insistence that its external review provisions merely mandate a "procedural right" (Pet. 11), those provisions can scarcely be considered "integral" to any insurance relationship. Like the state common law bad faith claim at issue in *Pilot Life*, Texas' IRO process "does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, [such as, in this case, coverage for "medically necessary" health care,] a breach of that contract may * * * allow a policyholder to

obtain" certain state law remedies. *Pilot Life*, 481 U.S. at 51.

In sum, because Texas' IRO provisions fail to "regulate insurance" from a common-sense view of the matter and clearly fail to satisfy any of the McCarran-Ferguson factors, those provisions cannot be viewed as "regulating insurance" within the meaning of Section 514(b)(2)(A). Accordingly, those provisions are independently preempted not only under Section 502(a), but also under Section 514(a).

3. In *Moran*, the Seventh Circuit recently held that ERISA does not preempt an Illinois statute's provisions requiring independent review of certain medical necessity decisions. *Moran*, 230 F.3d at 972-73. After concluding that the Illinois law falls "squarely" within ERISA's express preemption clause because it would affect benefit determination procedures (*id.* at 968), the court concluded that Section 514 does not invalidate Illinois' law because that law regulates insurance within the meaning of the saving clause, *id.* at 969-70. With respect to "conflict" preemption, the court determined that the Illinois statute's independent review provisions do *not* "creat[e] an alternative remedy scheme that conflicts with [§] 502(a)," but rather are incorporated into the terms of the insurance contract by operation of state law. *Id.* at 970. Thus, the court held, any suit to enforce the Illinois review procedures would be "simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by [§] 502(a)(1)(B)." *Id.*[9]

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[9] *Moran*'s state law analysis appears to be based upon an overly broad proposition of law that does not necessarily apply in this case. That proposition is that "Illinois laws automatically are incorporated into all contracts of insurance in that state." *Moran*, 230 F.3d at 966; *see also id.* at 969. In Texas, however, not every law is incorporated into every

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As Judge Posner recognized in dissenting from the Seventh Circuit's denial of rehearing *en banc*, the *Moran* panel's logic would permit the "transparent * * * evasion of ERISA's preemption clause," a result that is plainly impermissible. *Moran*, 230 F.3d at 972-73 (Posner, J., dissenting from denial of rehearing *en banc*). States could evade ERISA through the simple artifice of declaring that a state law that ERISA would otherwise preempt is "incorporated" into the terms of a plan. That anomalous analysis may merit this Court's review in an appropriate case, but review at this time would be premature. Only two courts of appeals have even considered whether ERISA preempts state laws that require external review, even though, according to Texas and its amici, "[m]any states" have adopted "some form of independent, external review process." Pet. 27 & n.24; *see also* Brief of the States of Massachusetts *et al.* as Amici Curiae in Support of Petitioners at 2 &. n.4.[10]

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contract of insurance. *See Jun v. Lloyds*, No. 03-00-00110-CV, 2000 WL 1675683, at *3-4 (Tex. App.-Austin, Nov. 9, 2000, no pet. hist.).

[10] Contrary to Texas' petition for certiorari, there is no conflict among other courts of appeals about whether ERISA preempts state independent review laws. *See* Pet. 13-15. The decisions from Second, Third, Sixth and Eighth Circuits on which Texas relies involved state insurance laws which, unlike the state independent review law at issue here, do not purport to establish additional *remedies* in conflict with § 502(a), but merely mandate minimum insurance *benefits*, like the insurance law held not preempted in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). *See Williams Ins. Trust*, 50 F.3d at 151 (state insurance law requiring that interest on life insurance benefits be computed from the date of death); *PAS*, 7 F.3d at 356-57 (state insurance law prohibiting discrimination in the provision of men-

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The widespread adoption of such laws should afford this Court ample opportunity to address the issues raised by Texas after several other courts of appeals have had an adequate opportunity to address the interrelation between external review laws and ERISA. Indeed, if Texas is correct that *Pegram* has some relevance to the preemption analysis that applies in this context—though neither the Fifth Circuit nor the Seventh Circuit believed that *Pegram* addressed the issues presented here—the very recency of that decision would itself counsel against review of Texas' arguments at this time, before the lower courts have had an adequate opportunity to assimilate that ruling.

As this Court has recognized, the percolation of important legal questions throughout the judicial system prior to a grant of a writ of certiorari offers this Court the benefits of enhanced development and consideration of the issues and of the various factual settings in which they arise. *See, e.g.*, *United States v. Mendoza*, 464 U.S. 154, 160 (1984); *E.I. du Pont de Nemours & Co. v. Train*, 430 U.S. 112, 135 n.26 (1977) (noting the "wisdom of allowing difficult issues to mature through full consideration by the courts of appeals"). That percolation could obviate any need for review altogether—by solidifying lower court support for the correct rule and

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tal health benefits); *Ruble v. UNUM Life Insurance Co. of Am.*, 913 F.2d 295, 297 (6th Cir. 1990) (state insurance law prohibiting insurance benefits from being reduced by any amount of social security benefits received); *Donatelli v. Home Insurance Co.*, 992 F.2d 763, 764-65 (8th Cir. 1993) (state insurance law requiring insurers to provide accidental death benefits in the event of death by suicide while insane). Unlike the state IRO procedures at issue here, those cases did not approve an alternate remedial scheme that directly conflicts with ERISA's civil enforcement provisions.

causing the Seventh Circuit to reconsider *Moran's* rule *en banc*.

Permitting further percolation of the preemption issue in the lower courts is particularly appropriate because the apparent disagreement between the Seventh and Fifth circuits may be rendered moot by federal legislative or regulatory developments. Leaders of both political parties are currently advocating separate versions of a Patients' Bill of Rights. *See, e.g.*, H.R. 2990, 106th Cong. (1999); H.R. 2723, 106th Cong. (1999); S. 1344, 106th Cong. (1999); S.Amend. 3694, 106th Cong. (2000); BNA's Health Care Daily Report, *Plan Regulation: Bill of Rights Could Make Comeback in Next Session; Business Groups Prepare*, Bureau of National Affairs, Inc. (Dec. 6, 2000). The Senate and House versions of that bill contain provisions for external independent review at Sections 121 and 1103, respectively. *See, e.g.*, H.R. 2990, 106th Cong. (1999). That legislation might well achieve many of the objectives of measures such as SB 386, without disrupting the nationally uniform regulation of employee benefit plans that Congress intended in ERISA. *Travelers*, 514 U.S. at 656.

In addition, less than three weeks ago the U.S. Department of Labor published a new ERISA regulation that revises the benefit claims procedures for ERISA plans. 65 Fed. Reg. 70246 (2000) (to be codified at 29 C.F.R. Part 2560). In particular, the regulation establishes new standards for the conduct of reviews of adverse benefit determinations with respect to group health plans and plans providing disability benefits. The regulation requires *de novo* review of such determinations by a third party fiduciary who is neither the individual who made the initial determination nor that person's subordinate. *Id.* at 70268-69 (to be codified at 29 C.F.R. Part 2560.503–1(h)). In addition, the review must take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or

relied upon in the initial determination. *Id.* at 70269. With regard to reviews of determinations based on a medical judgment, including medical necessity and appropriateness decisions, the regulation requires consultation with an appropriately qualified health care professional who is different from, and not subordinate to, any individual who was consulted in connection with the initial decision. *Id.* The effect of that new regulation on the issue of ERISA's preemption of state external review laws has yet to be evaluated by any lower federal court. In these circumstances, review by this Court of the decision below would be premature and unwarranted.

III. TEXAS HAS FAILED TO IDENTIFY ANY REASON WARRANTING REVIEW OF THE FIFTH CIRCUIT'S FEHBA RULING.

The court of appeals determined that FEHBA preempts SB 386's independent review procedures because those procedures squarely conflict with the administrative benefit review procedures established by the Office of Personnel Management under FEHBA. Pet. App. A17 (citing 5 U.S.C. § 8902(j); 5 C.F.R. § 890.105-890.107). Although Texas' second question ostensibly seeks review of that determination (see Pet. i), Texas presents no argument impugning the correctness of the court of appeals' FEHBA analysis and identifies no lower court conflict of any sort on that issue. Indeed, although the bulk of Texas' arguments under ERISA derive from Texas' assertion that SB 386 is a permissible regulation of insurance, FEHBA expressly preempts state laws relating to "insurance." See 5 U.S.C. § 8902(m)(1). Because Texas proffers no reason for this Court to review any FEHBA issue, this Court should consider Texas' FEHBA claim abandoned.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

JOHN B. SHELY
KENDALL M. GRAY
ANDREWS & KURTH LLP.
600 Travis, Suite 4200
Houston, Texas 77002
(713) 220-4200

MIGUEL A. ESTRADA
Counsel of Record
RACHEL A. CLARK
GIBSON, DUNN & CRUTCHER LLP
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Counsel for Respondents

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APPENDIX

CONSTITUTIONAL AND STATUTORY APPENDIX

CONSTITUTION OF THE UNITED STATES OF AMERICA
ARTICLE VI, CLAUSE 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

TEXAS SENATE BILL 386
AN ACT

relating to review of and liability for certain health care treatment decisions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 4, Civil Practice and Remedies Code, is amended by adding Chapter 88 to read as follows:

CHAPTER 88. HEALTH CARE LIABILITY

Sec. 88.001. DEFINITIONS. In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70–1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity'' means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

Sec. 88.002. APPLICATION. **(a)** A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse

to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of

Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

Sec. 88.003. LIMITATIONS ON CAUSE OF ACTION. **(a)** A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsection (c).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care

entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

> **(1)** harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and
>
> **(2)** the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim

against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

SECTION 2. Section 6, Article 21.58A, Insurance Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) The procedures for appeals must be reasonable and shall include the following:

(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination and shall be provided, on request, a clear and concise statement of the clinical basis for the adverse determination;

(2) a list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal;

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the

case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination;

(4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients, which shall include a health care provider who has not previously reviewed the case; such appeal must be completed no later than one working day following the day on which the appeal, including all information necessary to complete the appeal, is made to the utilization review agent; and

(5) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the 30th day after the date the utilization agent receives [~~30 days after receiving all the required documentation of~~] the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial;

(B) [~~and~~] the specialty of the physician making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under Section 6A of this article and the procedures for obtaining that review.

(c) Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization as provided by Section 6A of this article and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. For purposes of this sec-

tion, "life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

SECTION 3. Article 21.58A, Insurance Code, is amended by adding Section 6A to read as follows:

Sec. 6A. INDEPENDENT REVIEW OF ADVERSE DETERMINATIONS. A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

SECTION 4. Section 8, Article 21.58A, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) Confidential information in the custody of a utilization review agent may be provided to an independent review organization, subject to rules and standards adopted by the commissioner under Article 21.58C of this code.

SECTION 5. Subdivision (3), Subsection (a), Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), is amended to read as follows:

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act; and

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

(i) the medical, health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan or single health care service plan;

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, in-

cluding any deductible or co-payment feature;

(iii) where and in what manner information is available as to how services may be obtained; and

(iv) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

SECTION 6. Section 12, Texas Health Maintenance Organization Act (Article 20A.12, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 12. COMPLAINT SYSTEM. (a) Every health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees concerning health care services.

(b) The commissioner may examine the complaint system.

SECTION 7. The Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) is amended by adding Section 12A to read as follows:

Sec. 12A. REVIEW OF ADVERSE DETERMINATIONS. (a) The complaint system required by Section 12 of this Act must include:

(1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(3) notification to an enrollee who has a life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedures to obtain that review.

(b) The provisions of Article 21.58A, Insurance Code, that relate to independent review apply to a health maintenance organization under this section as if the health maintenance organization were a utilization review agent.

(c) In this section:

(1) "Adverse determination" means determination by a health maintenance organization that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary.

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

SECTION 8. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.58C to read as follows:

Art. 21.58C. STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS

Sec. 1. Definitions. In this article:

(1) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A of this code.

(2) "Payor" has the meaning assigned by Section 2, Article 21.58A of this code.

Sec. 2. CERTIFICATION AND DESIGNATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall:

(1) promulgate standards and rules for:

(A) the certification, selection, and operation of independent review organizations to perform independent review described by Section 6, Article 21.58A of this code; and

(B) the suspension and revocation of the certification;

(2) designate annually each organization that meets the standards as an independent review organization;

(3) charge payors fees in accordance with this article as necessary to fund the operations of independent review organizations; and

(4) provide ongoing oversight of the independent review organizations to ensure continued compliance with this article and the standards and rules adopted under this article.

(b) The standards required by Subsection (a)(1) of this section must ensure:

(1) the timely response of an independent review organization selected under this article;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(c) The standards adopted under Subsection (a)(1) of this section must include standards that require each independent review organization to make its determination:

(1) not later than the earlier of:

(A) the 15th day after the date the independent review organization receives the information necessary to make the determination; or

(B) the 20th day after the date the independent review organization receives the request that the determination be made; and

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the fifth day after the date the independent review organization receives the information necessary to make the determination; or

(B) the eighth day after the date the independent review organization receives the request that the determination be made.

(d) To be certified as an independent review organization under this article, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under Subdivision (3) of this subsection and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G) of this subdivision;

(5) the percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under Section 6A, Article 21.58A of this code;

(6) a description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(7) the procedures to be used by the independent review organization in making review determi-

nations with respect to reviews conducted under Section 6A, Article 21.58A of this code.

(e) The independent review organization shall annually submit the information required by Subsection (d) of this section. If at any time there is a material change in the information included in the application under Subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

(g) An independent review organization conducting a review under Section 6A, Article 21.58A of this code is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

SECTION 9. Chapter 88, Civil Practice and Remedies Code, as added by this Act, applies only to a cause of action that accrues on or after the effective date of this Act. An action that accrues before the effective date of this Act is governed by the law applicable to the action immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 10. (a) The change in law made by Sections 2 through 4 and 6 through 8 of this Act applies only to an adverse determination of a utilization review agent or health maintenance organization made on or after the effective date of this Act.

(b) The change in law made by Section 5 of this Act to Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), applies only to an evidence of coverage that is delivered, issued for delivery, or renewed on or after

January 1, 1998. An evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1998, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 11. This Act takes effect September 1, 1997.

SECTION 12. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE A—GENERAL PROVISIONS

* * * * *

Part 5—Administration and Enforcement

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§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action
A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under

the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title;

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a par-

ticipant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * * * *

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

* * * * *

(b) Construction and application

* * * * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insur-

ance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

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TITLE 5—GOVERNMENT ORGANIZATION AND EMPLOYEES
PART III. EMPLOYEES
SUBPART G. INSURANCE AND ANNUITIES
CHAPTER 89. HEALTH INSURANCE

§ 8902. Contracting Authority

* * * * *

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.